Special Health Care Needs (SHCN)
Guidelines for Submission of Claims

BILLING REMINDERS:

- The Provider must be an enrolled SHCN Provider.
- The Provider must bill SHCN within *60 calendar days* of the date of service or within *60 calendar days* of the Explanation of Benefits (EOB) process date.
- FAMILIES shall NOT be BILLED for approved SHCN services.
- SHCN is the payer of last resort.
- SHCN will only reimburse up to the amount of the family's responsibility.

The following supporting documentation shall accompany each claim:

HOSPITAL AND OFFICE VISIT CLAIMS:	Uniform Bill (UB-92)	Health Insurance Claim Form (HCFA-1500)	Medical reports/ records	Insurance EOB	Medicaid denial
PARTICIPANT WITHOUT INSURANCE OR MEDICAID					
Hospital claims require	X		X		
Office visit claims require		X	X		
PARTICIPANT WITH INSURANCE					
Hospital claims require	X		X	X	
Office visit claims require		X	X	X	
PARTICIPANT WITH MEDICAID					
Hospital claims require	X		X		X
Office visit claims require		X	X		X
PARTICIPANT WITH INSURANCE AND MEDICAID					
Hospital claims require	X		X	X	X
Office visit claims require		X	X	X	X

PHARMACY CLAIMS:

- Health Insurance Claim Form (HCFA-1500),
- Name of medication (generic and brand name),
- Usual and Customary Rate (UCR),
- Insurance EOB/insurance payment amount, and
- Family's financial responsibility (copay).

DURABLE MEDICAL EQUIPMENT (DME) CLAIMS:

- Health Insurance Claim Form (HCFA-1500),
- Prior Authorization required (if over $500),
- Insurance EOB (if applicable), and
- Medicaid denial (if applicable).

➢ **Reimbursement of charges shall be delayed if specified attachments are not received.**

➢ Review the SHCN billing guidelines at https://www.dhss.mo.gov/shcn/4_0.htm.

July 1, 2006

Special Health Care Needs (SHCN)
PO Box 570, Jefferson City, MO 65102
Phone: 573/751-6246 Fax: 573/751-6237 Billing Questions: 573/751-6245

This list is not all-inclusive.

SERVICES	PRIOR AUTHORIZATION (PA) REQUIREMENTS	REIMBURSEMENT RATE
Audiology	Not Required	80% of Usual & Customary Rate (UCR)
Augmentative Communication Evaluation/Device	Required	90% of Factory Rate
Dental - General Dentistry	Not Required	80% of UCR
Dental - Orthodontic Procedures	Required	80% of UCR
Disposable Supplies	Not Required	90% of UCR
Durable Medical Equipment - Purchase greater than $500 total cost	Required	90% of UCR
Durable Medical Equipment - Purchase less than $500 total cost	Not Required	90% of UCR
Durable Medical Equipment - Rental	Required	Negotiated thru prior authorization (PA).
Durable Medical Equipment - Repair	Required	90% of UCR
Ear Molds	Not Required	90% of UCR
Emergency Care Centers	Notification required within seventy two (72) hours to determine eligibility.	80% of UCR
Emergency Transportation	Notification required within seventy two (72) hours to determine eligibility.	80% of UCR
Facility Technical Component - Pathology	Not Required	80% of UCR
Facility Technical Component - Radiology	Not Required	80% of UCR
Hearing Aid Accessories - greater than $500 total cost	Required	90% of UCR
Hearing Aid Repair	Not Required	90% of repair charge plus shipping & handling in full.
Hearing Aids - greater than $500 total cost	Required	Wholesale cost plus 10%
Hearing Aids - less than $500 total cost	Not Required	Wholesale cost plus 10%
Hemophilia Factor	Not Required	Medicaid Rate
Inpatient Hospitalization - Diagnostic Evaluation	Required for greater than five (5) days stay.	Medicaid Per Diem.
Inpatient Hospitalization - Treatment of Eligible Condition	Required for greater than fourteen (14) days stay.	Medicaid Per Diem.
Medical Nutritional Services	Not Required	$10.50 per 15 minute unit of service
Occupational Therapy	Required for greater than five a (5) hours/week	$42 hour
Occupational Therapy Evaluation	Not Required	$42 hour
Office Visit - Pathology	Not Required	80% of UCR
Office Visit - Professional Service	Not Required	$15 for established patient, $60 for new patient.
Office Visit - Radiology	Not Required	80% of UCR
Office Visit - Special Procedure	Not Required	80% of UCR
Orthotic & Prosthetic Devices - greater than $500 total cost	Required	90% of UCR
Orthotic & Prosthetic Devices - less than $500 total cost	Not Required	90% of UCR
Outpatient Clinic	Not Required	80% of UCR

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Outpatient Clinic Visit - Pathology	Not Required	80% of UCR
Outpatient Clinic Visit - Professional Fee	Not Required	$8 for established patient, $25 for new patient.
Outpatient Clinic Visit - Radiology	Not Required	80% of UCR
Outpatient Clinic Visit - Special Procedure	Not Required	80% of UCR
Outpatient Surgery	Not Required	80% of UCR up to Medicaid inpatient per diem rate.
Physical Therapy	Required for greater than five (5) hours/week	$42 hour
Physical Therapy Evaluation	Not Required	$42 hour
Postage & Handling for Prescriptions	Not Required	In Full
Prescription Medications - Pharmacy	Not Required	90% of UCR
Prescription Medications - Physician's Office	Not Required	90% of UCR
Prescription Medications - Treatment Center	Not Required, Restricted to items on established formulary.	90% of UCR
Professional Fees - Inpatient - Anesthesiology	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Consultation	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Dental	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Emergency	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Pathology	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Radiology	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Special Procedures	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Professional Fees - Inpatient - Surgical (including oral/dental surgery)	Not Required	Less than $100, paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day.
Psychological Evaluation	Required	$60 hour
Respiratory Therapy	Required for greater than five (5) hours/week	$42 hour
Speech Therapy - Group	Required for greater than five (5) hours of individual and/or group combined/week	$14 hour
Speech Therapy - Individual	Required for greater than five (5) hours of individual and/or group combined/week	$42 hour
Speech/Language Evaluation	Not Required	$42 hour